09246

09243 Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Sykesville
LENGTH OF STAY (In this place) since 10/8/34
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY ---
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural, give location) 5407 Tramor Road

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
William	Wallace	BLAIR	October 19 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	single	May 6, 1883	71 yrs.	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Machine feeder	--- Unk -	Baltimore, Maryland	United States

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Mortigue Blair	Sarah Abraham

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
no ---	--- Unk -	Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Acute peritonitis	several days
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Perforated chronic gastric ulcer	" "
DUE TO		
	(c) ---	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Mental deficiency without psychosis — life long

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☒ No ☐
---	---	

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. ---	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY ---	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY --- M.	21e. INJURY OCCURRED --- While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR? ---

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James J. Branch M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒ DATE SIGNED 10/19/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10-21-54	Parkwood	Balto. City.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 19, 1954	C. Harry Tilden	William Cook Inc	1317 St Paul St.

RECEIVED
OCT 21 1954
BUREAU V. S.

09247

MARYLAND STATE DEPARTMENT OF HEALTH

09244

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Carroll; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Nr. Silver Run; LENGTH OF STAY (in this place) 10 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Myers District Westminster, Md. R. D. 1

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Silver Run, Myers District
STREET ADDRESS (If rural, give location) Westminster, Md. R.D.1

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) CALVIN (Last) BLANK
4. DATE OF DEATH: (Month) Oct (Day) 23 (Year) 19 54

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married
8. DATE OF BIRTH: 9/24/1887
9. AGE last birthday: 67 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Frederick County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William C. Blank
14. MOTHER'S MAIDEN NAME: Rose May Whipp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 214-28-1090
17. INFORMANT: Mrs John C. Blank Westminster, Md. R-1

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval between onset and death: Minute

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
James J. Marsh Deputy Medical Examiner Baltimore Md 10/23/54

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 10/27/54
NAME OF CEMETERY OR CREMATORY: Doubs Cemetery
LOCATION (City, town, or county) (State): Rockey Springs, Frederick Co. Md.

DATE REC'D BY LOCAL REG.: 11/24/54
REGISTRAR'S SIGNATURE: Hazel Miller
24. FUNERAL DIRECTOR ADDRESS: G. W. Little & Son. Littlestown, Pa.
Per O. A. Little

RECEIVED
OCT 26 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09245

09248

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 6 mths
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 24 3V01-4
STREET ADDRESS (If rural give location) 115 N. HIGHLAND AVE

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) — (Last) BRYDEN

4. DATE OF DEATH: (Month) Octber (Day) 21 (Year) 1954

5. SEX: fem. | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed | 8. DATE OF BIRTH: 11-30-1874 | 9. AGE last birthday 79 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife | 10B. KIND OF BUSINESS OR INDUSTRY: — | 11. BIRTHPLACE (State or foreign country): Scotland | 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Alexander GORDON

14. MOTHER'S MAIDEN NAME: Ann WRIGHT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No | (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 216-07-8282

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE 434	(A) Hypostatic bronchopneumonia	5 days
ANTECEDENT CAUSE (S)	DUE TO uremia	weeks
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) Hypertensive cardiovascular disease	years
	DUE TO	
	(C)	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Brain syndrome with senile brain disease, with psychotic reaction

19A. DATE OF OPERATION: 0 | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 21, 1954, to Oct 21, 1954, that I last saw the deceased alive on Oct. 21, 1954, and that death occurred at 10 P M, from the causes and on the date stated above.

SIGNATURE Gerhard Sonnenfeld M.D. ADDRESS Springfield State Hospital, Sykesville Md. DATE SIGNED 10-21-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 10/26/54 | NAME OF CEMETERY OR CREMATORY Maryland mem. Pk | LOCATION (City, town, or county) Baltimore (State) Md

DATE REC'D BY LOCAL REGISTRAR 10-25-54 | REGISTRAR'S SIGNATURE A.W. Hedrich

24. FUNERAL DIRECTOR Clarence F. Hoffman ADDRESS 7219 Lake ave

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

09246

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09249 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (In this place) 32 y 10 mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore, Md.
STREET ADDRESS (If rural give location) Unknown

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) Elizabeth (Last) Burns

4. DATE OF DEATH: (Month) 10 (Day) 22 (Year) 1954

5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single | 8. DATE OF BIRTH: 2-10-1889 | 9. AGE last birthday 65 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas L. Burns
14. MOTHER'S MAIDEN NAME: Anna Elizabeth Zilk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If no | (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1		
IMMEDIATE CAUSE	(A) Pulmonary embolism	minutes
ANTECEDENT CAUSE (S) DUE TO	cardiovascular disease	years.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO	(B) Allergic Dermatitis	4 days
	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Dementia precox, hebephrenic type	32 years +

19A. DATE OF OPERATION: 0
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-18, 1954 to 10-22, 1954 that I last saw the deceased alive on 10-22-, 1954, and that death occurred at 8 36 P, M, from the causes and on the date stated above.
SIGNATURE Walther H. Sommenfeldt M. D. ADDRESS Springfield State Hospital DATE SIGNED 10/22/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 10-25-54 | NAME OF CEMETERY OR CREMATORY Western | LOCATION (City, town, or county) (State) Balto. Md.

DATE REC'D BY LOCAL REGISTRAR Oct. 23, 1954 | REGISTRAR'S SIGNATURE C. Henry Lee | 24. FUNERAL DIRECTOR John T. Hussey, Inc. | ADDRESS 715 Light St. Balto.

RECEIVED
OCT 26 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09247

09250

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-5[illegible]

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural-Sykesville
LENGTH OF STAY (in this place) 19 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural-Sykesville, Maryland
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) Martha W. Chenowith

4. DATE OF DEATH: (Month) (Day) (Year) October 5, 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed

8. DATE OF BIRTH: Jan 30, 1902

9. AGE last birthday 52 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Tyler

14. MOTHER'S MAIDEN NAME: Mary Shockley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Walter E. Chenowith Sykesville, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

200.1

IMMEDIATE CAUSE (A) DUE TO Lymphosarcomatosis, geneal — INTERVAL BETWEEN ONSET AND DEATH: 6-8 mo

ANTECEDENT CAUSE (B) DUE TO Lymphosarcoma, femoral, left. — 1+ Yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1953, 19, to 5 Oct., 1954, that I last saw the deceased alive on 5 October, 1954, and that death occurred at 12:40 AM, from the causes and on the date stated above.

SIGNATURE M. D. ADDRESS DATE SIGNED
[signature] Sykesville P.O., Md. 10-5-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 10-8-54 | NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | LOCATION (City, town, or county) (State) Baltimore Co., Maryland

DATE REC'D BY LOCAL REGISTRAR Oct. 5-54 | REGISTRAR'S SIGNATURE Deputy Robert R. Hurst

24. FUNERAL DIRECTOR — ADDRESS C. M. Waltz Winfield, Maryland

RECEIVED
OCT 11 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09251 CERTIFICATE OF DEATH

09248

Reg. Dist. No. 7-7

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Hampstead RD#1
MARYLAND
LENGTH OF STAY (in this place) 4 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Valley Farm

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Hampstead
STREET ADDRESS (If rural give location) Grant Foster Road

3. NAME OF DECEASED: (Type or Print) (First) Chester (Middle) Adair (Last) Congdon

4. DATE OF DEATH: (Month) Oct (Day) 14 (Year) 1954

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M

8. DATE OF BIRTH: Dec 6 1915

9. AGE last birthday: 39 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Duluth Minn.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter B. Congdon

14. MOTHER'S MAIDEN NAME: Jessie Hartley

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) yes World War #

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Mrs. Chester A. Conda, Hampstead Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

Interval Between Onset And Death: 2 hrs

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fatty infiltration liver peripheral neuritis — 1 yr

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from N.D.V. ,1952, to Oct 14, 1954, that I last saw the deceased alive on Oct 12, 1954, and that death occurred at 6 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) W H Hoard M D ADDRESS Manchester Md DATE SIGNED 10/14/54

23. BURIAL, CREMATION, REMOVAL (Specify) Removal DATE THEREOF Oct 17 54 NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery LOCATION (City, town, or county) Duluth Minn. (State)

DATE REC'D BY LOCAL REGISTRAR 10/14/54 REGISTRAR'S SIGNATURE Henry J Reed

24. FUNERAL DIRECTOR C. V. Myers Jr, Westminster ADDRESS Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09249

09252 CERTIFICATE OF DEATH

Reg. Dist. No. [illegible]

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - [illegible]

1. PLACE OF DEATH
COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]ville
MARYLAND LENGTH OF STAY (In this place) 9 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Balt. City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) [illegible] Orchard Street

3. NAME OF DECEASED: (Type or Print) George (First) Francis (Middle) [illegible] (Last)

4. DATE OF DEATH: (Month) Oct. (Day) 23 (Year) 1954

5. SEX Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH: May 1, 1880. | 9. AGE last birthday 74 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) [illegible] Laborer | 10B. KIND OF BUSINESS OR INDUSTRY: [illegible] | 11. BIRTHPLACE (State or foreign country): Illinois | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Francis Conlee

14. MOTHER'S MAIDEN NAME: Amy Monhink

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) Spanish American | 16. SOCIAL SECURITY NO. [illegible] | 17. INFORMANT & ADDRESS: [illegible]

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Myocardial Infarction — Interval between onset and death: Minutes

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Arteriosclerotic Cardiovascular Disease — Years

DUE TO (C) Pulmonary Tuberculosis — [illegible]

SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE OR CONDITION CAUSING DEATH. Pos. [illegible]

19A. OPERATION: [illegible] | 19B. MAJOR FINDINGS OF OPERATION [illegible] | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 10, 19 54 to Oct. 23, 19 54, that I last saw the deceased alive on Oct. 23, 19 54, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

SIGNATURE Roy H. Hayes M. D. ADDRESS Spring Grove Hosp. DATE SIGNED 10/24/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Oct 27, 1954 | NAME OF CEMETERY OR CREMATORY Greenmount | LOCATION (City, town, or county) (State) Balto

DATE REC'D BY LOCAL REGISTRAR Oct 24, 1954 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR [illegible] | ADDRESS [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]

09253

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH

COUNTY Carroll — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]ville

LENGTH OF STAY (in this place) [illegible]

HOSPITAL OR INSTITUTION OR STREET ADDRESS [illegible]field State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland — COUNTY [illegible]

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible]

STREET ADDRESS (If rural give location) [illegible] Parkton, Maryland (Hereford)

3. NAME OF DECEASED: (Type or Print) (First) [illegible] (Middle) Adele (Last) Early

4. DATE OF DEATH: (Month) 10 (Day) 24 (Year) 1954

5. SEX: F

6. COLOR OR RACE: [illegible]

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) [illegible]

8. DATE OF BIRTH: 2-5-1873

9. AGE last birthday: 81 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): [illegible]wife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: [illegible]

14. MOTHER'S MAIDEN NAME: Redd Clements

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) [illegible] (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. [illegible]

17. INFORMANT & ADDRESS [illegible]

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE: 1 2 2.1

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Ruptured Intracranial aneurysm, ?basilar artery — 2 years

DUE TO (C) [illegible]sclerotic Cardiovascular Disease — Years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pernicious Anemia; Psych: Senile Psychosis, Simple Deterioration — 3 years

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 20 1954, to Oct. 24, 1954, that I last saw the deceased alive on October 24 1954 and that death occurred at 11 A M, from the causes and on the date stated above.

SIGNATURE Edmund Sutthaus M.D. ADDRESS [illegible]ield State Hospital DATE SIGNED 10/24/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF: 10-27-54 — NAME OF CEMETERY OR CREMATORY: Cedar Grove — LOCATION (City, town, or county) (State): Parkton, Md

DATE REC'D BY LOCAL REGISTRAR: Oct. 29 1954 — REGISTRAR'S SIGNATURE: [illegible]

24. FUNERAL DIRECTOR — ADDRESS: Brooks Funeral Service, Aberdeen, Md

[illegible] Dixon

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09251

09264

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster
LENGTH OF STAY (in this place) 3 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Church Home & Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY [redacted]
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [redacted]
STREET ADDRESS (If rural give location) [redacted]

3. NAME OF DECEASED: (Type or Print) (First) Emma (Middle) Case (Last) Crouse

4. DATE OF DEATH: (Month) Oct (Day) 30 (Year) 19 54

5. SEX: F. 6. COLOR OR RACE: W 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow 8. DATE OF BIRTH: 9-15-1868 9. AGE last birthday 86 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 10B. KIND OF BUSINESS OR INDUSTRY: Home 11. BIRTHPLACE (State or foreign country): Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: [redacted] 14. MOTHER'S MAIDEN NAME: Mary L. Crouse

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) — 16. SOCIAL SECURITY NO. [redacted] 17. INFORMANT & ADDRESS: [redacted]

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Coronary embolism — INTERVAL BETWEEN ONSET AND DEATH: 2-5 minutes

ANTECEDENT CAUSE (B) DUE TO hypertensive cardiovascular disease 10yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO senile changes; diabetes Mellitus (60 X)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. — 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ — 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 15, 1954, to 30 Oct, 1954, that I last saw the deceased alive on 30 October, 1954, and that death occurred at 7:50 P.M. from the causes and on the date stated above.

SIGNATURE [redacted] M.D. ADDRESS Aylesville P.O. Md. DATE SIGNED 11-1-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) [redacted] — DATE THEREOF 11-2-54 — NAME OF CEMETERY OR CREMATORY [redacted] — LOCATION (City, town, or county) (State) Glenwood, Howard, Md.

DATE REC'D BY LOCAL REGISTRAR Nov. 1 1954 — REGISTRAR'S SIGNATURE C. Harry Weer — 24 FUNERAL DIRECTOR [redacted] — ADDRESS [redacted]

09252

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09255

CERTIFICATE OF DEATH

Reg. Dist. No. 70

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown
MARYLAND
LENGTH OF STAY (In this place) 81 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Taneytown
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (First) A (Middle) Percy (Last) Garner

4. DATE OF DEATH (Month) October (Day) 31 (Year) 1954.

5. SEX M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): single

8. DATE OF BIRTH: April 9, 1873

9. AGE last birthday 81 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): labor

10B. KIND OF BUSINESS OR INDUSTRY: farm

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: E.O.Garner

14. MOTHER'S MAIDEN NAME: Emma Babylon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: Roy B.Garner, Taneytown,Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Chronic Myocarditis

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Arteriosclerosis

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 28, 1954, to Oct 31, 1954, that I last saw the deceased alive on Oct 31, 1954, and that death occurred at 8A M, from the causes and on the date stated above.

SIGNATURE J. H. Legg M. D. ADDRESS Union Bridge DATE SIGNED 11-2-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial

DATE THEREOF Nov. 2, 1954

NAME OF CEMETERY OR CREMATORY Lutheran

LOCATION (City, town, or county) (State) Taneytown,Md.

DATE REC'D BY LOCAL REGISTRAR Nov. 2, 1954

REGISTRAR'S SIGNATURE Ethel M Melvin

24. FUNERAL DIRECTOR C.O.FUSS & SON

ADDRESS Taneytow,Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09254

09256 CERTIFICATE OF DEATH Reg. Dist. No. 774

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

1. PLACE OF DEATH
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) since 2-17-53
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hosp.

2 USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY ----
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 3316 Cliftmont Ave

3. NAME OF DECEASED: (Type or Print) (First) Rosella (Middle) Birckgead (Last) German

4. DATE OF DEATH: (Month) Oct. (Day) 31 (Year) 1954

5. SEX: fem
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): wid
8. DATE OF BIRTH: 8-2-80
9. AGE last birthday: 74 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Henry James Birckgead
14. MOTHER'S MAIDEN NAME: Catherine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) ----
(If Yes, give war or dates of service) ----
16. SOCIAL SECURITY NO. ----
17. INFORMANT & ADDRESS. Records of Springfield Stata Hosp.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
J21X
IMMEDIATE CAUSE (A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: minutes
ANTECEDENT CAUSE (B) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Generalized arteriosclerosis with
DUE TO
(C) hypertension more than 2 yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. senile brain disease with psychosis " " "

19A DATE OF OPERATION: ----
19B. MAJOR FINDINGS OF OPERATION: ----
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) ---
21C WHERE DID INJURY OCCUR? (City or town) (County) (State) ----
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) ---- M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? ----

22. I hereby certify that I attended the deceased from 2-17, 1953, to 10-31, 1954, that I last saw the deceased alive on 10-31, 1954, and that death occurred at 10 P M, from the causes and on the date stated above.

SIGNATURE Martin Gross, M.D. Martin Gross, M.D. — ADDRESS Sykesville, Md — DATE SIGNED 10-31-54

23. BURIAL, CREMATION, REMOVAL, (SPECIFY) cremation
DATE THEREOF 11-3-54
NAME OF CEMETERY OR CREMATORY [illegible]
LOCATION (City, town, or county) (State) Towson, Md.

DATE REC'D BY LOCAL REGISTRAR Oct. 31, 1954
REGISTRAR'S SIGNATURE C. [illegible]
24 FUNERAL DIRECTOR [illegible] ADDRESS [illegible]

09255

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09257

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH.
COUNTY Carrol — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (In this place) since 10-2-1952
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) Southern House of Hospitality 2520 Fresh mount Ave

3. NAME OF DECEASED: (Type or Print) (First) Alice (Middle) L. (Last) Giles

4. DATE OF DEATH: (Month) 10 (Day) 24 (Year) 19 54

5. SEX: Female.

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): divorced

8. DATE OF BIRTH: Oct. 21, 1870

9. AGE last birthday: 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. a

13. FATHER'S NAME: Benjamin Bateman

14. MOTHER'S MAIDEN NAME: Laura A. Tarr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Arteriosclerotic heart Disease — INTERVAL BETWEEN ONSET AND DEATH more than 10 years

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Brain Syndrome associated with senile Psychotic Reaction about 2 years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-2-, 1954, to 10-24, 1954, that I last saw the deceased alive on 10-24-, 1954, and that death occurred at 8 P. M, from the causes and on the date stated above.

SIGNATURE Florian Hedrich M.D. M. D. ADDRESS Sykesville Md DATE SIGNED 10-24-1954

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 10-26-54 — NAME OF CEMETERY OR CREMATORY Loudon Park — LOCATION (City, town, or county) (State) Baltimore

DATE REC'D BY LOCAL REGISTRAR 10-25-54

REGISTRAR'S SIGNATURE A.W. Hedrich dmr.

24. FUNERAL DIRECTOR Thomas J. Sheehan ADDRESS 410 Wilkens Ave

09256

MARYLAND STATE DEPARTMENT OF HEALTH

09258

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 70

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bruceville
LENGTH OF STAY (In this place): 10 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bruceville
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Cornelius (Last) Glacken

4. DATE OF DEATH: (Month) Oct. (Day) 29 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: July 18, 1891

9. AGE Last Birthday: 63 yrs. — If under 1 year: Months / Days — If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Emmitsburg, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Micheal Glacken

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-24-6159

17. INFORMANT AND ADDRESS: Carroll Glacken, Baltimore, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Thrombosis	10 minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio-Sclerosis - Severe	10 years.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ✓, Inquiry ✓ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: Luther Barr, M.D. (Degree or title) — ADDRESS: Westminster Md — DATE SIGNED: 10/29/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 11/1/54
NAME OF CEMETERY OR CREMATORY: Union Cemetery
LOCATION (City, town, or county) (State): Fairfield, Penna.

DATE REC'D BY LOCAL REG.: Oct 31, 1954
REGISTRAR'S SIGNATURE: Ethel M Wearing
24. FUNERAL DIRECTOR — ADDRESS: C.O.Fuss & Son, Taneytown, Maryland

Local.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09257

09259 CERTIFICATE OF DEATH Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 2month22days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown
STREET ADDRESS (If rural give location) 394 N. Prospect Street

3. NAME OF DECEASED: (First) EDITH (Middle) LOVELSIE (Last) GRIM

4. DATE OF DEATH: (Month) OCTOBER (Day) 22 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married
8. DATE OF BIRTH: 1-12-1888
9. AGE last birthday 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Donald H. Stouffer
14. MOTHER'S MAIDEN NAME: Sarah ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unk-
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

H10X

IMMEDIATE CAUSE (A) Mitral Heart Disease — Years

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) Chronic Glomerulo-nephritis — Years

DUE TO

(C) Hypertension — Years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome associated with circulatory disturbance, with cerebral arterio-sclerosis, with psychotic reaction. 1 year+

19A. DATE OF OPERATION. V
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-30, 1954, to 10-22, 1954, that I last saw the deceased alive on 10-22, 1954, and that death occurred at 10:15 A M, from the causes and on the date stated above.

SIGNATURE Walter H Sommerdorf M. D. ADDRESS Springfield State Hospital DATE SIGNED 10-22-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Oct 25, 1954
NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
LOCATION (City, town, or county) (State) Hagerstown Md.

DATE REC'D BY LOCAL REGISTRAR Oct. 23, 1954
REGISTRAR'S SIGNATURE C. Harry Tilden
24. FUNERAL DIRECTOR Scott F Minnick & Son ADDRESS Hagerstown

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

09260 MARYLAND STATE DEPARTMENT OF HEALTH 09258

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 78

Items 8,9, FilmG172 11-1-54 et

1. PLACE OF DEATH: COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Taylorsville — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 3313 Liberty Hights Ave.

3. NAME OF DECEASED (Type or Print): (First) Louise (Middle) Imhoff (Last)

4. DATE OF DEATH: (Month) Oct. (Day) 25, (Year) 1954

5. SEX: female — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) S[illegible] — 8. DATE OF BIRTH: 10-25-[illegible]'66 — 9. AGE last birthday: 88 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): [illegible] — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY? Us

13. FATHER'S NAME: Unknown — 14. MOTHER'S MAIDEN NAME: Elizabeth Di[illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT AND ADDRESS Mrs. Abigail White Wallace 1517 Northern Park Way, [illegible]

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Fractured Skull - Broken Neck — Instant

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Street. — (CITY OR TOWN) Taylorsville — (COUNTY) Carroll — (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) 10- 25-54 2:15p.m. — INJURY OCCURRED While at work ☐ Not while at work ☑ — HOW DID INJURY OCCUR? Auto Accident

22. *I certify that I took charge of the remains described above, held an Autopsy _, Inspection ✓, Inquiry _ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [illegible], accident ✓, suicide _, homicide _, undetermined _.*

SIGNATURE Dr. C Satterfield — (Degree or title) M.D — ADDRESS Hampstead, Md — DATE SIGNED 10-25-54

23. BURIAL, CREMATION REMOVAL (Specify) — DATE THEREOF [illegible] — NAME OF CEMETERY OR CREMATORY Baltimore Cemetery — LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REG. 10-27-54 — REGISTRAR'S SIGNATURE E. M Farver — 24. FUNERAL DIRECTOR ADDRESS William J. Tickner & Sons, Balto. Md.

Local Reg

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

09261 **MARYLAND STATE DEPARTMENT OF HEALTH** 09259

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Carroll — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural-Mt. Airy — LENGTH OF STAY (in this place): yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Pursville
STREET ADDRESS (If rural, give location): Rural--Mt. Airy,

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
FRED		JOHNSON	Oct. 1, 19 54

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	colored	Widower	1859 ?	95 ? yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	General	Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	none	[illegible]

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chron. Myocarditis and Sen. Debility due to old age about 95—

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from July, 1942, to Oct 1, 1954 that I last saw the deceased alive on Sept 30, 19 54, and that death occurred at 3 P m., from the causes and on the date stated above.

SIGNATURE: Clinton Poole MD (Degree or title) ADDRESS: Pikesville, Md DATE SIGNED: 10-1-54

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	10-4-1954	Simpsons Chapel	Howard Co., Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct 3, 1954	Robert L. Hewitt	C. M. Waltz,	Winfield, Maryland

OCT 5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09260

09262

CERTIFICATE OF DEATH

Reg. Dist. No. 81

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN Union Bridge — LENGTH OF STAY (in this place) 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Bridge
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) ROY (Middle) CLIFTON (Last) JOHNSON

4. DATE OF DEATH: (Month) Oct. (Day) 17 (Year) 1954

5. SEX: male — 6. COLOR OR RACE: white — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married — 8. DATE OF BIRTH: 12/23/1886 — 9. AGE last birthday: 67 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Carpenter - Contractor — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Johnson — 14. MOTHER'S MAIDEN NAME: Margaret Groft

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no — (If Yes, give war or dates of service) no — 16. SOCIAL SECURITY NO.: 216-07-7928 — 17. INFORMANT & ADDRESS: Isabel C. Johnson, Union Bridge, Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset And Death: 4 attacks

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b)
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-16, 1954, to 10-17, 1954, that I last saw the deceased alive on 10-16, 1954, and that death occurred at 8 A M, from the causes and on the date stated above.
SIGNATURE (Degree or title) J. H Legg M D — ADDRESS Union Bridge Md — DATE SIGNED 10/17/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 10/20/54 — NAME OF CEMETERY OR CREMATORY Hughes Cemetery — LOCATION (City, town, or county) Keymar Md (State)

DATE REC'D BY LOCAL REGISTRAR Oct. 19, 1954 — REGISTRAR'S SIGNATURE Lulie L Repp — 24. FUNERAL DIRECTOR D. D. Harbaugh & Sons — ADDRESS Union Bridge, Md

S. A. DIVISION
OCT

09263

MARYLAND STATE DEPARTMENT OF HEALTH

09261

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 26

1. PLACE OF DEATH: COUNTY Carroll — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near Westminster — LENGTH OF STAY (in this place) 13 yr
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. 7

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near Westminster
STREET ADDRESS (If rural, give location) R.D. 4

3. NAME OF DECEASED (Type or Print): (First) JACOB (Middle) ELMER (Last) LING

4. DATE OF DEATH: (Month) Oct. (Day) 20 (Year) 1954

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct. 10, 1890

9. AGE last birthday: 64 yrs. — If under 1 year: Months / Days — If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Peter Ling

14. MOTHER'S MAIDEN NAME: Mary Ann Elmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-05-8807

17. INFORMANT AND ADDRESS: Mrs. Catherine Hiltebrick

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Alcoholism	4 Days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chr. Nephritis	2 years
	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Body found 12 hours after death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22 *I certify that I took charge of the remains described above, held an Autopsy __, Inspection __, Inquiry __ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Lincoln Bankard M.D. (Degree or title) — ADDRESS Westminster Md. — DATE SIGNED 10/11/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Oct 12 1954 — NAME OF CEMETERY OR CREMATORY Union Bridge — LOCATION (City, town, or county) (State) Union Bridge Md.

DATE REC'D BY LOCAL REG. 10-11-54 — REGISTRAR'S SIGNATURE Herbert Miller — 24. FUNERAL DIRECTOR Harner Funeral Home — ADDRESS Union Bridge Md.

VS. A15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct spelling of names is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09264

09264

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
LENGTH OF STAY (in this place) 82 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. 4

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Westminster
STREET ADDRESS (If rural, give location) R.D. 4

3. NAME OF DECEASED: (Type or Print) (First) KATIE (Middle) MAY (Last) KING

4. DATE OF DEATH: (Month) October (Day) 3 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: March 4, 1872

9. AGE last birthday: 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Andrew J. White

14. MOTHER'S MAIDEN NAME: Mary Ann Ryland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Jacob Wilmer King R.D. 4 Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Uremia — Interval Between Onset and Death: 1 week

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Cardio Renal Disease — Many years

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Senile Debility — Progressive

19a. DATE OF OPERATION: 10-20

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) — INJURY OCCURRED While at work ☒ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-15, 1954, to 10-3, 1954, that I last saw the deceased alive on 10-2, 1954, and that death occurred at 12:50 p.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) — ADDRESS — DATE SIGNED

W. L. Stone M.D. Westminster

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 5, 1954	Fairview Cemetery	Westminster R.D. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-5-1954	Homer C. Smith	H. Bankard & Son	Westminster Md.

OCT 6
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 69263

09265 CERTIFICATE OF DEATH Reg. Dist. No. .....

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 2 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore, Zone 6
STREET ADDRESS (If rural give location) 7506 Marks Avenue

3. NAME OF DECEASED: (Type or Print) (First) Anna (Middle) K. (Last) Lassahn

4. DATE OF DEATH: (Month) Oct. (Day) 28 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed

8. DATE OF BIRTH: July 4th 1873 Not known

9. AGE last birthday 81 ? yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -------

10B. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? Unknown, U.S.A.

13. FATHER'S NAME: Not known

14. MOTHER'S MAIDEN NAME: Not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. -----

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE	(A) Pneumonia	several days
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) DUE TO Hypertensive heart disease	many years
	(C) DUE TO Diabetes mellitus	years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CBS with psychosis		years

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-10 , 1954, to 10-28 , 1954 that I last saw the deceased alive on 10-28 , 1954, and that death occurred at 12:20 M, from the causes and on the date stated above.

SIGNATURE A. Lubiejka M.D. ADDRESS Springfield Hospital DATE SIGNED 10/28/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 10/30/54

NAME OF CEMETERY OR CREMATORY Immanuel Lutheran

LOCATION (City, town, or county) (State) Balto. City Md

DATE REC'D BY LOCAL REGISTRAR 10-29-54

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR Lassahn Funeral Home ADDRESS 7407 Belair Rd

09264

MARYLAND 09266

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

1. PLACE OF DEATH
COUNTY Carroll County — MARYLAND
CITY If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodbine Sykesville, Md | LENGTH OF STAY (in this place) 35 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS none.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE ~~Woodbine Sykesville~~ COUNTY Carrol
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodbine / Carroll Co.
STREET ADDRESS (If rural, give location) rural

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	HOWARD	none	Leatherwood		Oct.	8	19 54

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
M	W		11 June 1873	81 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Carroll Count
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Owen Leatherwood
14. MOTHER'S MAIDEN NAME: Sarah ??
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT AND ADDRESS: ~~Brother~~ Samuel Leatherwood Woodbine

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac arrest -

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary thrombosis - Cardiac asthma

(c) arteriosclerosis -

INTERVAL BETWEEN ONSET AND DEATH: April 54 ↓ Oct 54

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
0	0	Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
c	0	Woodbine, Md.		

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
0			m.		

22. I hereby certify that I attended the deceased from April, 19 54 to Oct, 19 54, that I last saw the deceased alive on 8 Oct, 19 54, and that death occurred at 10:30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Howard E Hall M.D. ADDRESS Sykesville, Md DATE SIGNED 8 Oct 54

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY ~~or Crematory~~	LOCATION (City, town, or county) (State)
BURIAL	10-11-1954	Morgan Chapel	Carroll Co., Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-10-54	Deputy - Robert R. Hewitt	C. M. Waltz,	Winfield, Maryland

MARGIN RESERVED FOR BINDING

OCT 13
BUREAU V. S

15

09267 09265

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville, Md.
LENGTH OF STAY (in this place) 26 Yrs.4 Mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) (Last) Lewis

4. DATE OF DEATH (Month) Oct. (Day) 23, (Year) 19 54

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Single	4-14-1893	61 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Dependant
10b. KIND OF BUSINESS OR INDUSTRY: —0—
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edmund Lewis
14. MOTHER'S MAIDEN NAME: Caroline Harrison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unk-
17. INFORMANT & ADDRESS: Edmund Lewis, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			Interval Between Onset and Death
Immediate cause	(a)	Acute myocardial Infarct	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b)	Epilepsy	55 Years
	DUE TO (c)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: **19b. MAJOR FINDING OF OPERATION:** **20. AUTOPSY?** Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY
21c. (City or town) (County) (State)
21d. TIME (Month) OF (Day) (Year) INJURY (Hour) M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James L. Brooks M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☒
DATE SIGNED Dec 23/54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	10/26/54	Hillcrest Cemetery	Cumberland	Md

DATE REC'D BY LOCAL REG. Oct. 24 '54 | REGISTRAR'S SIGNATURE C. Henry Tilden
24. FUNERAL DIRECTOR John J. Hafer ADDRESS Cumb., Md.

VS. A15A - 5 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09268 09266

CERTIFICATE OF DEATH

Reg. Dist. No. 70

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Taneytown
LENGTH OF STAY (in this place) 25 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural-Taneytown
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Lena (Middle) Miller (Last) Lieb

4. DATE OF DEATH: (Month) October (Day) 10, (Year) 19 54

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Widow	Oct. 2, 1883	71 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housework	Own home	Germany	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Miller	Marie Schnider

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no		none	Fred. Lieb, Taneytown, Maryland

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) Chronic Myocarditis + Myocardial Degeneration	10 yrs.
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) Hypertension, Vascular DUE TO	15 yrs.
	(C) Arteriosclerosis, Generalized	20 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Diabetes Mellitus	8 yrs.

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21E. INJURY OCCURRED While at work ☐ Not while at work ☐	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 4, 1939, to Oct. 10, 1954, that I last saw the deceased alive on Oct. 8, 1954, and that death occurred at 6 A. M, from the causes and on the date stated above.

SIGNATURE R. S. McVaugh M. D. ADDRESS Taneytown Md. DATE SIGNED 10/11/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10/13/54	Lutheran Cemetery	Taneytown, Maryland

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 11, 1954	Adel M. Mehring Reg	C.O.Fuss	& Son, Taneytown, Maryland

OCT 13
BUREAU V. S.

09269

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. 40267

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 80

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the figures of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor — LENGTH OF STAY (In this place) 6 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural - Hoarstown

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN New Windsor Rural
STREET ADDRESS (If rural, give location) Hoarstown

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CARROLL LEWIS LINDSAY	Oct. 15 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
male	white	married	1/10/1903	51 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Dairy Plant - Manager		Maryland	U.S.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Leslie Lindsay	Nadie Franklin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no - no	212-03-5383	Mabel S. Lindsay, New Windsor, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Coronary Occlusion	Minutes
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b)	
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] M. D. — CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ — DATE SIGNED 10/15/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10/18/54	St. James' Cem.	Carroll County, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10/17/54	Grace S. Bucklet	D. D. Hartzell & Sons	New Windsor, Md.

VS. A15A - 5 - 53

09270 MARYLAND STATE DEPARTMENT OF HEALTH 09268

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster (Rural) LENGTH OF STAY 30 yrs. (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Hook Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Carroll COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster (Rural)
STREET ADDRESS (If rural, give location) Rte. 6

3. NAME OF DECEASED (Type or Print): (First) Herbert (Middle) Cleveland (Last) Miller
4. DATE OF DEATH: (Month) October (Day) 29 (Year) 1954
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH: April 10, 1887
9. AGE last birthday: 67 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: General Carpenter
11. BIRTHPLACE (State or foreign country): Pleasant Valley, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: George W. Miller
14. MOTHER'S MAIDEN NAME: Elouse Hoppe (married)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 220-09-3035
17. INFORMANT AND ADDRESS: Mrs. Herbert C. Miller, Westminster, Md. Rt. 6

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Shot Gun Wound of left chest	Inst.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Epilepsy	Life
	(c) Depression	4 months

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.*

SIGNATURE: M C Porterfield (Degree or title) M.D ADDRESS Hampstead, Md DATE SIGNED 10/29/54

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE THEREOF Oct 31 54 NAME OF CEMETERY OR CREMATORY Sam Parks, Cemetery LOCATION (City, town, or county) Smallwood Carroll Co. Md. (State)

DATE REC'D BY LOCAL REG. Oct 29 1954 REGISTRAR'S SIGNATURE Grace Fuller

24. FUNERAL DIRECTOR J. E. Myers, Jr. ADDRESS Westminster Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09269

09271

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1 PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Henryton
LENGTH OF STAY (in this place) 2yrs.6mos.19days
HOSPITAL OR INSTITUTION OR STREET ADDRESS HENRYTON STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 24
STREET ADDRESS (If rural give location) 912 S. Baylis St

3. NAME OF DECEASED: (Type or Print) (First) AUGUSTA (Middle) (Last) MOORE

4. DATE OF DEATH: (Month) OCT. (Day) 15 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Nov. 3, 1903
9. AGE last birthday: 51 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: Private family
11. BIRTHPLACE (State or foreign country): Whiteville, N.Carolina
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Brown
14. MOTHER'S MAIDEN NAME: Annie McKee

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service)
16. SOCIAL SECURITY No: 212-32-4345
17. INFORMANT & ADDRESS: Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Far adv. pul. tbc. bilat. — Interval Between Onset And Death: 3½ yrs.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-4 ,1952 , to 10-15 , 1954 , that I last saw the deceased alive on 10-15 , 1954, and that death occurred at 8:25 , from the causes and on the date stated above.

SIGNATURE T.H. Lestal (Degree or title) M.D
ADDRESS Henryton, Maryland
DATE SIGNED 10-15-54

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
DATE THEREOF Oct 24, 1954
NAME OF CEMETERY OR CREMATORY Clarkston Cem.
LOCATION (City, town, or county) Clarkston Co. (State) M.C.

DATE REC'D BY LOCAL REGISTRAR 10-15-54
REGISTRAR'S SIGNATURE Albert R. Brandt Deputy Local
24. FUNERAL DIRECTOR William A. Jackson Funeral Home Inc.
ADDRESS 916 penna. ave

OCT
BUREAU

09272 09270

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY CARROLL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN TANEYTOWN
LENGTH OF STAY (in this place) 3 YR
HOSPITAL OR INSTITUTION OR STREET ADDRESS ROUTE 1 M

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD — COUNTY CARROLL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN TANEY TOWN
STREET ADDRESS (If rural, give location) ROUTE 1 M

3. NAME OF DECEASED (Type or Print): (First) OSCAR (Middle) B (Last) PALMER

4. DATE OF DEATH: (Month) OCT (Day) 30 (Year) 1954

5. SEX MALE — WHITE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH NOV 29, 1888

9. AGE last birthday 65 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST

10b. KIND OF BUSINESS OR INDUSTRY MACHINE SHOP

11. BIRTHPLACE (State or foreign country) MD

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 220-32-3215

17. INFORMANT AND ADDRESS FLORENCE S. PALMER ROUTE 1 M

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute coronary occlusion	15 min
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Atherosclerosis of coronary artery	2 months
	(c) Hemorrhagic arteriosclerosis	6 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-3, 1953, to 10-30, 1954, that I last saw the deceased alive on 10-27, 1954, and that death occurred at 1:10 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Walter E. Sheets, M.D. Taneytown, Md. 10-30 54

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL

DATE THEREOF 11/1/54

NAME OF CEMETERY OR CREMATORY PARKWOOD

LOCATION (City, town, or county) (State) TAYLOR AVE

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE A. R. Formby JR

24. FUNERAL DIRECTOR Paul E. Lohmeyer — ADDRESS 310-11 Elmira Ave

09271

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09273

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 23 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Garrett
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland
STREET ADDRESS (If rural give location) 53 Wilson Street

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) BARNES (Last) PORTER

4. DATE OF DEATH: (Month) October (Day) 9 (Year) 1954

5. SEX: fem.

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: July 10, 1894

9. AGE last birthday: 60 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): school teacher

10B. KIND OF BUSINESS OR INDUSTRY: Teaching

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George A. Porter

14. MOTHER'S MAIDEN NAME: Emma Herd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk.
(If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSE (S) DUE TO Hypertensive cardiovascular disease — 23 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Peptoulcer Coronary 7 years ago; Dementia precox — 23 years and 7 days

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 15, 1950, to Oct. 9, 1954, that I last saw the deceased alive on Oct. 8, 1954, and that death occurred at 5:30 A M, from the causes and on the date stated above.

SIGNATURE Gertrude Sonnenfeld (M.D.), Springfield State Hospital — ADDRESS Sykesville Md. — DATE SIGNED 10-9-1954

23. BURIAL, CREMATION, REMOVAL, (SPECIFY) Burial

DATE THEREOF 10-12-54

NAME OF CEMETERY OR CREMATORY Oakland

LOCATION (City, town, or county) (State) Oakland, Garrett Co., Md.

DATE REC'D BY LOCAL REGISTRAR Oct. 10, 1954

REGISTRAR'S SIGNATURE C. Harry Wiser

24. FUNERAL DIRECTOR Nobel C. Leighton — ADDRESS Oakland, Md.

OCT 1
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 69272

09274

CERTIFICATE OF DEATH

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN MANCHESTER
LENGTH OF STAY (in this place) 3 YRS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MANCHESTER

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY CARROLL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MANCHESTER
STREET ADDRESS (If rural give location) MANCHESTER

3. NAME OF DECEASED: (Type or Print) (First) Luther (Middle) C (Last) Sauerhammer

4. DATE OF DEATH: (Month) October (Day) 28 (Year) 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Married	Sept 7-1883	71 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Railroad	B+O	PA.	

13. FATHER'S NAME: SAUERHAMMER

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
			MRS L. MAY SAUERHAMMER, MANCHESTER MD.

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) Coronary Thrombosis	1 hr
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Aortic Insufficiency	9 yrs
	DUE TO (c) Chronic Myocarditis	9 yrs

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1951, to Oct 28, 1954, that I last saw the deceased alive on 10/14/, 1954, and that death occurred at 6 A.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
W. H. Hoard	M. D.	Manchester Md	10/28/54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	OCT. 30/54	LOUDON PARK	BALTO. MD.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
October 30 1954	R.W.	Harry H. Smith & Co	4101 EDMONDSON AVE.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 ~~09275~~ 09273

CERTIFICATE OF DEATH

Reg. Dist. No. 7

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middleburg
LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Middleburg
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Daisy (Middle) Coleman (Last) Sherman

4. DATE OF DEATH: (Month) Oct. (Day) 3, (Year) 19 54

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: April 15, 1880

9. AGE last birthday: 74 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10B. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Coleman

14. MOTHER'S MAIDEN NAME: Lucretta Eyler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: Mrs. Earl Rakestraw, Middleburg, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cardiac dilatation — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Diabetes — 8 yrs

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1954 to 10-3-, 1954, that I last saw the deceased alive on 10-3-, 1954, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

SIGNATURE J. H. Legg M. D. ADDRESS Union Bridge DATE SIGNED 10-5-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 10/6/54

NAME OF CEMETERY OR CREMATORY Middleburg Cemetery

LOCATION (City, town, or county) (State) Middleburg, Maryland

DATE REC'D BY LOCAL REGISTRAR Oct 5, 1954

REGISTRAR'S SIGNATURE Ethel M Mehring

24. FUNERAL DIRECTOR ADDRESS C.O.Fuss & Son, Taneytown, Maryland

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09274

09276 CERTIFICATE OF DEATH

Reg. Dist. No. 7.5

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) OR TOWN Manchester
LENGTH OF STAY (in this place) 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md — COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manchester
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (First) ANNA (Middle) BANGE (Last) SMITH
4. DATE OF DEATH: (Month) Oct (Day) 7 (Year) 1954

5. SEX: F
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: June 21 1880
9. AGE last birthday: 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): York Co. Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lee Bange
14. MOTHER'S MAIDEN NAME: Emma Kraft

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Geo. H. Bange Manchester, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset And Death: 1 day

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Hypertension — 5 yrs
DUE TO (c) Rheumatoid Arthritis — 10 yrs

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 9, 1951, to Oct 7, 1954, that I last saw the deceased alive on Oct 7, 1954, and that death occurred at 7.10 P.M. from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED
W. H. Foard M. D. Manchester Md 10/8/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Oct. 11 1954
NAME OF CEMETERY OR CREMATORY Stone Church
LOCATION (City, town, or county) (State) Brodbeck York

DATE REC'D BY LOCAL REGISTRAR Oct 8-54
REGISTRAR'S SIGNATURE Mrs Ivan Donner
24. FUNERAL DIRECTOR H. Keefer
ADDRESS New Salem Pa
H. Keefer

Or Foard Manchester Md

MARYLAND 09277 09275 STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH
COUNTY Carrol — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville | LENGTH OF STAY (In this place) 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield St. Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage
STREET ADDRESS (If rural, give location) R. D. #1, Mt. Savage, Md.

3. NAME OF DECEASED (Type or Print): (First) Edna (Middle) Grace (Last) Sweene

4. DATE OF DEATH: (Month) 10 (Day) 17 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: 1-22-82

9. AGE last birthday: 72 yrs. | If under 1 year: Months — Days — | If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George — Unk —

14. MOTHER'S MAIDEN NAME: Jane Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): Unk —

16. SOCIAL SECURITY NO.: Unk —

17. INFORMANT AND ADDRESS: Francis H. Sweene, Cumberland, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Old new infarct of heart	years & days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Heart Disease	years
	(c) Pneumonia	days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes, CVD with pyelonephritis — years

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/2/54, to 10/17/54, that I last saw the deceased alive on 10/17/54, and that death occurred at 10/17/54 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Gertrud Sonnenfeld M.D. — ADDRESS Springfield State Hospital Sykesville Md. — DATE SIGNED 10/18/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE 10-21-54 — NAME OF CEMETERY OR ~~CREMATORY~~ St. Mary's — LOCATION (City, town, or county) (State) Allegany Co., Md.

DATE REC'D BY LOCAL REG. Oct. 18, 1954 — REGISTRAR'S SIGNATURE C. Harry Eckard

24. FUNERAL DIRECTOR — ADDRESS E. J. Dimeler Son - Frostburg, Md.

MARGIN RESERVED FOR BINDING

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09276

09244 CERTIFICATE OF DEATH Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Westminster
LENGTH OF STAY (in this place) 7 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS New Windsor Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carrol
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster
STREET ADDRESS (If rural give location) New Windsor Road

3. NAME OF DECEASED: (Type or Print) (First) Mabel (Middle) Annie (Last) Taylor

4. DATE OF DEATH: (Month) October (Day) 9 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: May 20 1889

9. AGE last birthday: 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Flore England

12. CITIZEN OF WHAT COUNTRY? England

13. FATHER'S NAME: George Meacock

14. MOTHER'S MAIDEN NAME: Maria Jeffries

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) -

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: John M Taylor Westminster Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral hemorrhage DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Paralysis Agitans DUE TO

(c)

Interval Between Onset And Death: 36 hrs

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1, 1953, to Oct 9, 1954, that I last saw the deceased alive on Oct 9, 1954, and that death occurred at 3:30 AM, from the causes and on the date stated above.

SIGNATURE Julius Chepko (Degree or title) M.D. ADDRESS 130 E. Green Westminster Md. DATE SIGNED Oct 11, 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Oct 12 1954 NAME OF CEMETERY OR CREMATORY St Thomas Cemetery LOCATION (City, town, or county) Garrison Forest (State) Md

DATE REC'D BY LOCAL REGISTRAR Oct 11 1954 REGISTRAR'S SIGNATURE Hamet Miller

24. FUNERAL DIRECTOR Wm Berryman & Sons ADDRESS Reisterstown Md

OCT 13
BUREAU V. S.

09277

09278 MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY [illegible] MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible]
LENGTH OF STAY (In this place) 22 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS [illegible]

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE [illegible] COUNTY [illegible]
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible]
STREET ADDRESS (If rural, give location) [illegible]

3. NAME OF DECEASED (Type or Print) (First) ABRAM (Middle) [illegible] (Last) [illegible]

4. DATE OF DEATH (Month) [illegible] (Day) [illegible] (Year) 19[illegible]

5. SEX [illegible] 6. COLOR OR RACE [illegible] 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) [illegible] 8. DATE OF BIRTH [illegible] 9. AGE last birthday [illegible] yrs. If under 1 year: Months [illegible] Days [illegible] If under 24 hrs.: Hours [illegible] Min. [illegible]

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) [illegible]
10b. KIND OF BUSINESS OR INDUSTRY [illegible]
11. BIRTHPLACE (State or foreign country) [illegible]
12. CITIZEN OF WHAT COUNTRY? [illegible]

13. FATHER'S NAME [illegible]
14. MOTHER'S MAIDEN NAME [illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [illegible] (If yes, give war or dates of service) [illegible]
16. SOCIAL SECURITY NO. [illegible]
17. INFORMANT AND ADDRESS [illegible]

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset and Death: about 15 min

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) [illegible]
(c) [illegible]

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. [illegible]

19a. DATE OF OPERATION [illegible] 19b. MAJOR FINDINGS OF OPERATION [illegible] 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) [illegible] PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY [illegible] (CITY OR TOWN) [illegible] (COUNTY) [illegible] (STATE) [illegible]

TIME OF INJURY (Month) [illegible] (Day) [illegible] (Year) [illegible] (Hour) [illegible] m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR? [illegible]

22. I hereby certify that I attended the deceased from Oct 1, 1953, to Oct 16, 1954 that I last saw the deceased alive on Oct 12, 1954, and that death occurred at 5 A.M., from the causes and on the date stated above.

SIGNATURE [illegible] (Degree or title) M.D. ADDRESS [illegible] DATE SIGNED 10/17/54

23. BURIAL, CREMATION, REMOVAL (Specify) [illegible] DATE THEREOF Oct 18 1954 NAME OF CEMETERY OR CREMATORY [illegible] LOCATION (City, town, or county) [illegible] (State) [illegible]

DATE REC'D BY LOCAL REG. [illegible] REGISTRAR'S SIGNATURE [illegible] 24. FUNERAL DIRECTOR [illegible] ADDRESS [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09278

09279

CERTIFICATE OF DEATH

Reg. Dist. No. 70

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Taneytown
LENGTH OF STAY (in this place) 19 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural-Taneytown
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) S. (Last) Valentine

4. DATE OF DEATH: (Month) (Day) (Year) October 1, 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow

8. DATE OF BIRTH: May 13, 1866

9. AGE last birthday: 88 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10B. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Shorb

14. MOTHER'S MAIDEN NAME: Ellen Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: Mrs. E. Gregg Kiser, Taneytown, Maryland

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) Acute cardio respiratory failure	3 hours.
ANTECEDENT CAUSE (S)	DUE TO (B) Cerebro vascular accident - Thrombus - rt	2 days
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (C) Generalized Arterio-sclerosis	15 years.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7 June 1940 to 1 Oct, 1954, that I last saw the deceased alive on 1 Oct., 1954 and that death occurred at 10:10 AM, from the causes and on the date stated above.

SIGNATURE Walter E. Stevens M. D. ADDRESS Taneytown, Md. DATE SIGNED 1 Oct 54

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

DATE THEREOF: 10/4/54

NAME OF CEMETERY OR CREMATORY: Keysville Union Cemetery

LOCATION (City, town, or county) (State): Keysville, Maryland

DATE REC'D BY LOCAL REGISTRAR: Oct. 7, 1954

REGISTRAR'S SIGNATURE: Ethel M Mehring Local

24. FUNERAL DIRECTOR ADDRESS: C.O.Fuss & Son, Taneytown, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09279

09280

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sykesville, Maryland
LENGTH OF STAY (in this place) 1 Mo. 6 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
STREET ADDRESS (If rural give location) 9210 Ewing Drive

3. NAME OF DECEASED: (Type or Print) (First) Augusta (Middle) Victoria (Last) Wallis

4. DATE OF DEATH: (Month) 10 (Day) 25 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: 5-18-84

9. AGE last birthday: 70 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unk —

10B. KIND OF BUSINESS OR INDUSTRY: Unk —

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? Naturalized U.S.A.

13. FATHER'S NAME: Louie Wallis

14. MOTHER'S MAIDEN NAME: Annie —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. [redacted]

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — 422.1

IMMEDIATE CAUSE (A) Myocardial degeneration, with — INTERVAL BETWEEN ONSET AND DEATH: month

ANTECEDENT CAUSE (S): DUE TO arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C) Cerebral arteriosclerosis

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-19, 1954 to 10-25.., 1954 that I last saw the deceased alive on 10-25, 1954, and that death occurred at 8:20A M, from the causes and on the date stated above.

SIGNATURE Gertrude M. Gross, M.D. — ADDRESS — DATE SIGNED 10-25-54

Gertrude M. Gross, M.D.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal — DATE THEREOF 10-25-54 — NAME OF CEMETERY OR CREMATORY — LOCATION (City, town, or county) (State) 3605-14th St. N.W.

DATE REC'D BY LOCAL REGISTRAR 10-25-54 — REGISTRAR'S SIGNATURE C. Henry Tilden

24. FUNERAL DIRECTOR Geier's Funeral Home — ADDRESS 3605-14th St N.W. Wash. D.C.

VS. A15 — 10 - 5.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

09280

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09281

CERTIFICATE OF DEATH

Reg. Dist. No. 7d

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Harney
LENGTH OF STAY (in this place) lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md — COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Harney
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Maude (Middle) L (Last) Wantz

4. DATE OF DEATH: (Month) Oct. (Day) 15 (Year) 1954.

5. SEX: F — 6. COLOR OR RACE: W — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed — 8. DATE OF BIRTH: April 29, 1881 — 9. AGE last birthday: 73 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework — 10B. KIND OF BUSINESS OR INDUSTRY: own home — 11. BIRTHPLACE (State or foreign country): Md — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George W. Weant — 14. MOTHER'S MAIDEN NAME: Elizabeth Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) — 16. SOCIAL SECURITY NO. none — 17. INFORMANT & ADDRESS: Mrs. Floyd R. Strickhouser—Taneytown R#2

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) Acute Coronary Artery Occlusion	36 hrs.
ANTECEDENT CAUSE (S) DUE TO	(B) Angina Pectoris	8 yrs.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO	(C) Coronary Arteriosclerosis	10 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Generalized Arteriosclerosis	10 yrs.

19A. DATE OF OPERATION: 0 — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. — 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ — 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/29, 1941, to 10/15, 1954, that I last saw the deceased alive on 10/15, 1954, and that death occurred at 7:00 P.M., from the causes and on the date stated above.

SIGNATURE R. S. McVaugh — M.D. ADDRESS Taneytown, Md. — DATE SIGNED Oct. 16, 1954

23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial — DATE THEREOF Oct. 18, 1954. — NAME OF CEMETERY OR CREMATORY Piney Creek — LOCATION (City, town, or county) (State) Taneytown, Rural Md.

DATE REC'D BY LOCAL REGISTRAR Oct. 18. 1954 — REGISTRAR'S SIGNATURE Ethel M Melvin

24. FUNERAL DIRECTOR — ADDRESS C. O. Fuss & Son, Taneytown, Maryland

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09281

09282 CERTIFICATE OF DEATH Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville, Maryland
MARYLAND
LENGTH OF STAY (in this place) 19 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural give location) 3739 Park Heights Avenue

3. NAME OF DECEASED: (Type or Print) (First) Solomon (Middle) -- (Last) Weinberg

4. DATE OF DEATH: (Month) 10 (Day) 1 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: ?/1897 (?)

9. AGE last birthday: 57 (?) yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Yard -

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Weinberg

14. MOTHER'S MAIDEN NAME: Ida (?)

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No.

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset And Death 1/2 hr.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Ch. Myocarditis — ?

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ---

19b. MAJOR FINDINGS OF OPERATION ---

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) ---

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY ---

(CITY OR TOWN) (COUNTY) (STATE) -----

TIME OF INJURY (Month) (Day) (Year) (Hour) m. -----

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? -----

22. I hereby certify that I attended the deceased from 12-6- ,1935, to 10-1- ,1954, that I last saw the deceased alive on 10-1-, 1954, and that death occurred at 2:15 P.M. from the causes and on the date stated above.

SIGNATURE, H. N. Martin, M.D. (Degree or title) — ADDRESS Springfield State Hosp., Sykesville, Md. — DATE SIGNED 10-1-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 10-3-54 — NAME OF CEMETERY OR CREMATORY Druid Israel — LOCATION (City, town, or county) Balto (State) Md

DATE REC'D BY LOCAL REGISTRAR Oct. 2, 1954 — REGISTRAR'S SIGNATURE D. Henry Weer — 24. FUNERAL DIRECTOR Jack Levin Inc — ADDRESS 2100 Eutaw Pl

VS. A15

OCT 5
BUREAU V. S

09283

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09282
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Rd Westminster
LENGTH OF STAY (in this place) 63yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5 Willow Ct.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rd Westminster
STREET ADDRESS (If rural, give location) 5 Willow Ct.

3. NAME OF DECEASED: (Type or Print) (First) JOSEPH (Middle) ANTHONY (Last) WILL

4. DATE OF DEATH (Month) October (Day) 7 (Year) 1954

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: August 10, 1901

9. AGE last birthday: 53 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Laborer Tanning

10b. KIND OF BUSINESS OR INDUSTRY: B.F. Shriver Co.

11. BIRTHPLACE (State or foreign country): Altoona, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Andrew Will

14. MOTHER'S MAIDEN NAME: Mary Ebine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-03-5878

17. INFORMANT & ADDRESS: Hazel Green Will 5 Willow Court Westminster Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) DUE TO Coronary Occlusion — Interval Between Onset and Death Minutes

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: **19b. MAJOR FINDING OF OPERATION:** **20. AUTOPSY?** Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. **21b. PLACE** (Home, farm, factory, OF street, office bldg., etc., INJURY **21c.** (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. **21e. INJURY OCCURRED** While at work ☐ Not while at work ☐ **21f. HOW DID INJURY OCCUR?**

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James J. Mauch M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒ DATE SIGNED Dec 9-1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial **DATE THEREOF** Oct. 11, 1954 **NAME OF CEMETERY OR CREMATORY** St. Clayssius Cemetery **LOCATION** (City, town, or county) Littlestown (State) Pa.

DATE REC'D BY LOCAL REG. 10-12-54 REGISTRAR'S SIGNATURE [illegible] **24. FUNERAL DIRECTOR** ADDRESS Bankard Son Littlestown, Md.

VS. A15A - 5 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09284 **CERTIFICATE OF DEATH** Reg. Dist. No. 09283 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) Henryton
LENGTH OF STAY (in this place) 11mos. 28 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01
STREET ADDRESS (If rural give location) 716. W. Fayette St

3. NAME OF DECEASED: (Type or Print) (First) ALFRED (Middle) (Last) WILLIAMS
4. DATE OF DEATH: (Month) Oct. (Day) 12 (Year) 19 54

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Separated
8. DATE OF BIRTH: Jan.,1,1999
9. AGE last birthday: 55 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Revere Copper & Brass
11. BIRTHPLACE (State or foreign country): Lynchburg, Va.,
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Bill Williams
14. MOTHER'S MAIDEN NAME: Anna Kilroy

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 578-01-7367
17. INFORMANT & ADDRESS: /Deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Mod. Adv. pul. bilat. tbc. DUE TO — Interval Between Onset And Death: approx 2 1m

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-14-53, to 10-12-54, 19 54, that I last saw the deceased alive on 10-12-54, 19 54, and that death occurred at 12:45 A.M., from the causes and on the date stated above.

SIGNATURE T.F. Hestal (Degree or title) M.D. ADDRESS Henryton, Md DATE SIGNED 10-13-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 10/15/1954 NAME OF CEMETERY, OR CREMATORY Mt. Auburn Cem. LOCATION (City, town, or county) (State) Baltimore Co. Md.

DATE REC'D BY LOCAL REGISTRAR 10-12-54 REGISTRAR'S SIGNATURE Elmer R. Smallwood, Deputy Local
24. FUNERAL DIRECTOR Mrs Kate R Wall Wenzel ADDRESS

RECEIVED
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09284

09285 **CERTIFICATE OF DEATH** Reg. Dist. No. 17

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

—MARGIN RESERVED FOR BINDING

VS. A15—10-

1 PLACE OF DEATH
COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
MARYLAND LENGTH OF STAY (in this place) 24 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield STate Hospital

2 USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 13
STREET ADDRESS (If rural give location) 1907 N. Register St.

3 NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) AMBROSE (Last) WILLIAMS

4. DATE OF DEATH: (Month) October (Day) 25 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) ~~Divorced~~

8. DATE OF BIRTH: 1-20-70

9. AGE last birthday 84 yrs | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B KIND OF BUSINESS OR INDUSTRY: IRON FOUNDRY

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Williams

14. MOTHER'S MAIDEN NAME: Rebecca Harrison Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 218-09-2172

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE 4477

(A) Cardio-vascular disease DUE TO — INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) Hypertension and arteriosclerosis DUE TO — Years

(C)

II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome due to arteriosclerosis. 1 yr.+

19A OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-21, 1954, to 10-15, 1954, that I last saw the deceased alive on 10-15, 1954, and that death occurred at 11:45 A M, from the causes and on the date stated above.

SIGNATURE Walther L. Sonnenfeldt M.D. ADDRESS Springfield State Hospital DATE SIGNED 10-15-54

23 BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Oct 18, 1954 — NAME OF CEMETERY OR CREMATORY Parkwood Cemetery — LOCATION (City, town, or county) Baltimore Md (State)

DATE REC'D BY LOCAL REGISTRAR Oct 16, 1954 — REGISTRAR'S SIGNATURE R.W.

24 FUNERAL DIRECTOR Henry Sander & Son, Inc. — ADDRESS Balto. Md.

MARYLAND 09286

09285
STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH
COUNTY Carroll County — MARYLAND
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Sykesville — LENGTH OF STAY (in this place) 10 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital Sykesville, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural—Clarksville, R.F.D. #1
STREET ADDRESS (If rural, give location) 13X

3. NAME OF DECEASED (Type or Print) (First) Helen Elizabeth (Middle) Conaway (Last) Wolfe

4. DATE OF DEATH (Month) 10 (Day) 6 (Year) 1954

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH 1-30-87

9. AGE last birthday 67 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Conaway

14. MOTHER'S MAIDEN NAME Sarah E. Neary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Unk. — (If year, give war or dates of service) —

16. SOCIAL SECURITY NO. Unk-

17. INFORMANT AND ADDRESS Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebrovascular accident — 15 min.

Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Hypertensive arteriosclerotic cardiovascular disease — many years
(c) Diabetis Mellitus — " "

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. C.B.S. associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-17, 1954, to 10-6, 1954, that I last saw the deceased alive on 10-5, 1954, and that death occurred at 5 30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) C. D. Borowski MD — ADDRESS Springfield State Hosp. — DATE SIGNED 10-6-54

23. BURIAL, CREMATION, REMOVAL, (Specify) Burial — DATE 10-9-54 — NAME OF CEMETERY OR CREMATORY Waugh Chapel — LOCATION (City, town, or county) (State) A. A. Co., Md.

DATE REC'D BY LOCAL REG. Nov. 6, 1954 — REGISTRAR'S SIGNATURE C. Henry Tilley

24. FUNERAL DIRECTOR Birkett Donaldson — ADDRESS Laurel, Md.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09286

09287 # CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 54

1. PLACE OF DEATH:
COUNTY [illegible]
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible] ✓
MARYLAND
LENGTH OF STAY (in this place) 12y. 8mo. 12da.
HOSPITAL OR INSTITUTION OR STREET ADDRESS [illegible]

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE [illegible] COUNTY [illegible]
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown Rt 2
STREET ADDRESS (If rural give location) [illegible]

3. NAME OF DECEASED: (Type or Print) (First) FRANK (Middle) E. (Last) WOLFORD

4. DATE OF DEATH: (Month) October (Day) 29 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: [illegible]

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): [illegible]

8. DATE OF BIRTH: [illegible] 1869

9. AGE last birthday: 84 yrs. IF UNDER 1 YEAR: Months [illegible] Days [illegible] IF UNDER 24 HRS.: Hours [illegible] Min. [illegible]

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): [illegible]

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: [illegible]

14. MOTHER'S MAIDEN NAME: Henrietta Wolf

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. [illegible]

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Perforated peptic ulcer & Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Aortic Stenosis — years

DUE TO (C) Arteriosclerotic Cardio-vascular — years

II SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. fracture of rt hip — abt. 5 weeks

19A. DATE OF OPERATION: [illegible]

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work [ ] Not while at work [ ]

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-1, 1950 to Oct. 29, 1954 that I last saw the deceased alive on Oct. 29, 1954., and that death occurred at 10:28 M, from the causes and on the date stated above.

SIGNATURE Walter H. Immenschuh M. D. ADDRESS Springfield State Hospital DATE SIGNED 10/31/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — DATE THEREOF: Nov-2-54 — NAME OF CEMETERY OR CREMATORY: St Paul's — LOCATION (City, town, or county) (State): Hagerstown Md.

DATE REC'D BY LOCAL REGISTRAR: Nov. 2, 1954 — REGISTRAR'S SIGNATURE: [illegible]

24. FUNERAL DIRECTOR: C. H. Sutermaster — ADDRESS: Hagerstown Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09245

CERTIFICATE OF DEATH

09287

Reg. Dist. No. 52

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Westminster 2-7
LENGTH OF STAY (in this place) 70 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 58 Madison St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster 2-7
STREET ADDRESS (If rural, give location) 58 Madison

3. NAME OF DECEASED: (Type or Print) (First) GEORGE (Middle) MARSHALL (Last) ZENTZ

4. DATE OF DEATH: (Month) Oct. (Day) 16 (Year) 1954

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: June 23-1884

9. AGE last birthday: 70 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter Employee

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Amos Zentz

14. MOTHER'S MAIDEN NAME: Mary E. Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No

16. SOCIAL SECURITY NO.: (If Yes, give war or dates of service) 216-01-9985

17. INFORMANT & ADDRESS: Cecelia Beard 4021 Ninth St. Washington D.C. N.W.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

202.1

Immediate cause (a) Mediastinal Lymphoma — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1950, to 10/16, 1954, that I last saw the deceased alive on 10/15, 1954, and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) James J. Shook M.D. ADDRESS Md. DATE SIGNED 10/18/54

23. BURIAL, CREMATION / REMOVAL (Specify): Burial

DATE THEREOF Oct. 19-1954

NAME OF CEMETERY OR CREMATORY Krider's Cemetery

LOCATION (City, town, or county) Westminster (State) Md.

DATE REC'D BY LOCAL REG. Oct 19 54

REGISTRAR'S SIGNATURE Harriet Miller

24. FUNERAL DIRECTOR H. Bankard & Son ADDRESS Westminster, Md.

RECEIVED
OCT 20 1954
BUREAU V. S.

09288

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09288

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 54

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 1month10days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 31
STREET ADDRESS (If rural give location) 2115 Bank Street

3. NAME OF DECEASED: (Type or Print) (First) STANISLAUS (Middle) (Last) ZUKOWSKI, SR.

4. DATE OF DEATH: (Month) October (Day) 1 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: [illegible] 1890

9. AGE last birthday 64 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman

10B. KIND OF BUSINESS OR INDUSTRY: Retard

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY? Poland

13. FATHER'S NAME: Thomas Zukowski

14. MOTHER'S MAIDEN NAME: Eva Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) Pulmonary tuberculosis, far-advanced	years
ANTECEDENT CAUSE (S) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) Aspiration pneumonia	6 weeks
DUE TO	(C) Suicidal laceration of throat	1½month ago
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Involutional psychosis	5 years

002X

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-20, 1954, to 10-1, 1954, that I last saw the deceased alive on 10-1-, 1954, and that death occurred at 8:10 A M, from the causes and on the date stated above.

SIGNATURE Walther H. Sommerfeld M. D. ADDRESS Springfield State Hospital DATE SIGNED October 1, 1954

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Oct 5/54

NAME OF CEMETERY OR CREMATORY Holy Rosary Cem.

LOCATION (City, town, or county) (State) Balto. County

DATE REC'D BY LOCAL REGISTRAR 10/4/54

REGISTRAR'S SIGNATURE U. A. Hedrick

24. FUNERAL DIRECTOR John M. Wilbey ADDRESS 401 S. Chester Street